| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115626 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/29/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Hazelhurst Court Care and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 180 Burkett Ferry Road Hazlehurst, GA 31539 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interviews, and policy titled Food Storage the facility failed to ensure that food was properly labeled and dated and in sanitary conditions to prevent foodborne illness. The practice has the potential to affect 55 residents of 58. Findings include:A tour with dietary manager on 03/27/2026 at 8:20 AM revealed the following concerns:1.Observation on 03/27/2026 of the freezer was found with a large bag of broccoli opened and not labeled, two packs of dumplings that were past the expiration date, a pack of spinach that had passed the expiration date, and a box of what appeared to be frozen cinnamon rolls that were open with no date or label.2. Observation on 03/27/2026 of the pantry revealed four boxes of lasagna and one gallon jug of Worcestershire sauce, that were not dated.3. Observation on 03/27/2026 in the kitchen at one of the perp stations revealed five seasoning containers that were opened and not dated, one pancake and waffle syrup that was opened and not dated, two cans of cooking spray that were open and not dated, one gallon bottle of barbeque sauce open and not dated, two bottles of lemon juice opened and not dated, one bag of brownie mix with an expired date, one bag of corn meal mix open and not dated, one container of salt with an expired date, and one jar of mayonnaise that was not dated.Interview during the tour with Dietary Manager of the kitchen on 03/27/2026 confirmed all of the surveyor 's identified concerns. Further interview revealed that she is responsible to ensure all food is labeled with open dates/ expired dates to ensure safety of residents. The Dietary Manager revealed she will educate her staff again on labeling and dating food items. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on interview and observation, the facility failed to ensure adherence to established laundry maintenance protocols related to dryer lint trap cleaning. This deficient practice has the potential to affect 58 residents. Findings Include:During an observation on 03/28/2026 at 8:40 AM it was observed that the lint filter of the second dryer that is located near the window had not been cleaned.During an interview on03/28/2026, at 10:52 AM, the Environmental Services Director (ESD) stated that lint traps are required to be cleaned after each use or, at a minimum, every hour, with staff required to document completion. However, the ESD confirmed that the lint trap in the second dryer had not been cleaned in accordance with facility policy. The ESD also confirmed that if the lint filters are not cleaned it could cause a fire. |

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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff and family representative, and facility policy titled, Resident Trust Fund, the facility failed to notify the resident and/or residents' responsible party when their personal funds were within $200 of the Social Security Income (SSI) limit and when accounts had exceeded the amount for one of 39 accounts reviewed, resident (R)45. Findings include:Facility policy Resident Trust Fund dated 07/1/2025 revealed 6. Monitoring Balances: Per OBRA regulations, a resident on medical assistance must be notified whenever their funds are within $200 of their resource asset limit. Fund balances for Medicaid recipients should be monitored monthly by the Resident Trust Custodian to ensure that state maximum balances are not exceeded. The Resident Trust Custodian is responsible for sending a notification letter to the resident/responsible party whenever their funds are within $200 of their resource limit.Review of R45's medical record revealed she was diagnosed with but not limited to dementia in other diseases classified elsewhere, severe without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, cognitive communication deficit, and dementia in other diseases classified elsewhere, mild, with agitation. The quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment.Review of the Resident Statement Landscape report dated revealed R45's trust fund accounts exceeded the SSI limit of $2000 for 12 months, February 2025 to February 2026.During an interview on 03/28/2026 at 12:39 PM with the [NAME] President (VP) of Revenue Cycle Management for [NAME] revealed there is no longer a Business Officer Manager (BOM) working in the facility, rather she handles all of the resident accounts. The VP reported she was informed to keep resident fund accounts under $2000 to qualify for Medicaid. She admitted that since she took over R45's account she has not followed up with the Medicaid Eligibility Officer regarding the resident's account being over $2000 for the last 12 months. The VP stated the resident is now in a Medicaid eligibility review period and will lose her Medicaid. The VP advised she was unsure if the resident and or her representative were receiving written notifications that R45's account was over $2000. She stated the receptionist oversees notifying residents and or their representatives.Interview on 03/28/2026 at 12:59 PM with receptionist revealed that part of her responsibility was to notify residents and or their representatives of their accounts reaching within $200 of $2000. She stated she has not sent any written notifications to R45's representative since she started in June 2025 but did give them to R45. She acknowledged the resident's BIMS was a 5 which indicates a severe cognition impairment. Interview on 03/29/2026 at 10:30 AM with R45's representative, a family member, revealed the facility keeps in contact with her and notifies her of any changes that R45 may have. The representative stated she was recently at the facility on March 11, 2026, for the resident's care plan meeting. She confirmed that she had never received any financial notices or statements from the facility. Interview on 03/29/2026 at 10:55 AM with Social Services revealed she contacted R45's family representative to ask her to spend down the resident's account by prepaying burial/funeral arrangements. Social Services revealed she did not notify the family representative that R45's account was over $2000 because she does not handle resident finances. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observations, resident and staff interviews, and record review, the facility failed to follow the comprehensive care plan for a resident requiring assistance with personal hygiene (nail care) and oxygen therapy management for two of 24 residents (R) (R28 and R31) sampled. This deficient practice had the potential to place the residents at risk for unmet care needs.<br><br>Findings include:<br><br>Review of the facility's policy titled RAI/CARE PLANNING MANAGEMENT dated August 2017 under the Interim Care Plan section revealed, C. Based on the nursing admission assessment, the attending physician orders and other information, immediate resident needs are identified, effective interventions are implemented and measurable goals are established . Further review of the policy under the The Care Plan section revealed, The Baseline care plan will be the guide for the comprehensive care plan.<br><br>1. Record review of the Electronic Medical Record (EMR) revealed that R28 had diagnoses that included but not limited to, type 1 diabetes mellitus with hyperglycemia, other reduced mobility, and need for assistance with personal care.<br><br>Record review of the care plan date initiated 12/25/2025 revealed R28 required assistance with bathing related to decreased mobility, weakness, cognitive impairment, or safety concerns with interventions that included but not limited to: assist resident with bathing as needed per resident schedule, monitor skin for redness, breakdown, rashes, or bruising during bathing and nurse to assist resident with nail care on scheduled bath days and prn.<br><br>Record review of the facility's bath schedule revealed, R28 was scheduled on Monday, Wednesday, and Fridays on night shift.<br><br>Observations on 03/27/2026 at 9:38 AM, at 1:46 PM, and on 3/28/2026 at 8:25 AM, revealed R28 had long, untrimmed fingernails with visible debris containing a brown substance underneath the nail beds.<br><br>During an observation and interview on 03/28/2026 at 9:45 AM with Certified Nursing Assistant (CNA) AA, she confirmed R28 had long, untrimmed fingernails with a brown substance underneath them. CNAs and Nurses were responsible for providing nail care on bath days.<br><br>Observation and interview on 03/28/2026 at 9:50 AM with Licensed Practical Nurse (LPN) BB and CNA CC both confirmed R28 had long, untrimmed fingernails with a brown substance underneath them. LPN BB revealed she was the nurse assigned to R28 and that nurses and CNAs were responsible for nail care.<br><br>Interview on 03/29/2026 at 8:20 AM with Registered Nurse (RN) MDS Coordinator revealed that she was responsible for developing care plans and that her expectation of staff was to follow the care plan.<br><br>2. Review of the medical record for R31 revealed diagnoses that included but are not limited to acute chronic respiratory failure with hypoxia.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Physician Orders dated 02/14/2026 revealed orders for oxygen at two liters per minute via nasal canula.<br><br>Review of care plan revealed a diagnosis acute respiratory failure with hypoxia. Interventions included but not limited to: Administer medications as prescribed or per standing order.<br><br>Interview on 03/28/2026 at 9:44 AM with Minimum Data Set (MDS) Coordinator revealed she develops and enters care plans. She revealed R31's physician order was for the oxygen rate to be set at two liters per minute. The MDS Coordinator revealed her expectations of staff were to follow the care plan and confirmed 1.5 liters per minute was the wrong setting. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and record review, the facility failed to ensure nail care was provided for one of 24 sampled residents (R) (R28) reviewed for Activities of Daily Living (ADL) care. Specifically, R28 was observed with long, untrimmed fingernails with visible debris containing a brown substance underneath the nail beds.Findings include:Record review of the facility's policy titled Resident Hygiene dated January 2025 under the Policy section revealed, Bathing includes cleaning and trimming fingernails and toenails, shaving facial hair, washing the entire body, and shampooing residents hair. Under the section titled Care of Fingernails/Toenails the Policy statement revealed, Nail care includes daily cleaning and regular trimming. Nail trimming diabetic residents are per MD (Medical Director) order. Podiatry care is scheduled as needed for those residents with identified podiatry needs.Record review of the Electronic Medical Record (EMR) revealed, R28 had diagnoses that included but not limited to, type 1 diabetes mellitus with hyperglycemia, other reduced mobility, and need for assistance with personal care. Record review of R28's admission Minimum Data Set (MDS) assessment dated [DATE] under Sections C (Cognitive Patterns), a Brief Interview for Mental Status (BIMS) score of 7; Section E (Behavior) for the Rejection of Care section revealed, behavior not exhibited and Section GG (Functional Status) revealed that the resident was dependent on staff to provide ADL care.Record review of the facility's bath schedule revealed, R28 was scheduled on Monday, Wednesday, and Fridays on night shift.Record review of the facility's Documentation Survey Report from January 2026 through March 2026 revealed no evidence of refusal for ADL bathing or personal hygiene related to nail care.Observations on 03/27/2026 at 9:38 AM, at 1:46 PM, and on 03/28/2026 at 8:25 AM, revealed R28 had long, untrimmed fingernails with visible debris containing a brown substance underneath the nail beds.During an observation and interview on 03/28/2026 at 9:45 AM with Certified Nursing Assistant (CNA) AA, she confirmed R28 had long, untrimmed fingernails with a brown substance underneath them.Observation and interview on 3/28/2026 at 9:50 AM with Licensed Practical Nurse (LPN) BB and CNA CC both confirmed R28 had long, untrimmed fingernails with a brown substance underneath them. LPN BB revealed she was the nurse assigned to R28 and that nurses and CNAs were responsible for nail care. During an interview on 03/28/2026 at 10:06 AM with the Director of Nursing confirmed that R28's fingernails were long, untrimmed and had a brown substance underneath them. She revealed that her expectations was staff provide nail care on bath days as scheduled. During an interview on 03/29/2026 at 8:45 AM with Registered Nurse (RN) Unit Manager, she confirmed R28 had a diagnosis of diabetes. She reported that CNAs were responsible for providing nail care to residents and that Nurses were responsible for trimming the nails of residents who were diabetics. Her expectations of staff were to offer nail care on bath days and as needed. The RN Unit Manager reported that if she had refused or they were uncomfortable with cutting R28 nails, they should have documented this. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff interviews, and review of the facility's policy titled, Respiratory System Management, the facility failed to ensure a concentrator was in working order so that the physician's order for oxygen administration was followed for one of 14 residents (R) (R31) reviewed for oxygen administration. The deficient practice had the potential to place the resident at risk for medical complications, unmet needs and a diminished quality of life.Findings include:Review of the facility's undated policy titled Respiratory System Management under the section titled Oxygen, Administration-Nasal Cannula procedures 1. Check the physician's orders in the resident's clinical record 5. turn the flow meter to the ordered flow rate. Review of the of medical record for R31 revealed diagnoses that included but are not limited to acute chronic respiratory failure with hypoxia.Review of 31's admission Minimum Data Set (MDS) assessment dated [DATE] revealed, Sections C (Cognitive Patterns)- a Brief Interview of Mental Status (BIMS) of 7; Section J (Health Conditions)-Shortness of Breath (SOB); Section O (Special Treatments, Procedures, and Programs)- received oxygen therapy Review of Physician Orders dated 02/14/2026 revealed orders for oxygen at two liters per minute via nasal canula. Observations on 03/27/2026 at 8:50 AM and 2:25 PM revealed R31 lying in bed receiving oxygen therapy via nasal canula at 1.5 liters per minute. Observation on 03/28/2026 at 9:12 AM revealed R31 lying in bed receiving oxygen via nasal cannula at 1.5 liters per minute.Observation and rounding on 03/28/2026 at 9:32 AM with the Director of Nursing (DON) revealed R31 lying in bed receiving oxygen via nasal cannula at 1.5 liters per minute. The DON revealed nurses were responsible for making sure the oxygen setting was set on the prescribed rate during medication pass and rounding. The DON verified the rate should be set at two liters per minute. Interview on 03/28/2026 at 9:34 AM with Licensed Practical Nurse (LPN) GG confirmed the physician order for R31's oxygen was 2 LPM. She revealed she checks the oxygen setting during each medication pass and during rounding. She stated she had not checked R31's oxygen as of 9:34 AM. Interview on 03/29/26 at 8:30 AM with the DON revealed she checked the oxygen rate of R31 around 7:45 AM and it was off by a half liter due to the concentrator being faulty. She stated she contacted someone to fix the concentrator. She was unsure how long the concentrator had been broken. |